STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155694	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETZ NURSING HOME	116 BETZ RD AUBURN, IN 46706

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 27, 28, 29, 30, and 31, 2012 Facility number: 000306 Provider number: 155694 AIM number: 100273860 Survey team: Diane Nilson, RN, TC Sue Brooker, RD Angela Strass, RN Rick Blain, RN Census bed type: SNF/NF: 100 NCC: 4 Total: 104 Census payor type: Medicare: 14 Medicaid: 58 Other: 32 Total: 104 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/06/12 by Suzanne Williams, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a physician order was followed regarding a medication decrease for 1 resident in a sample of 10 residents who were reviewed for unnecessary medications (Resident #126). Findings include: Review of the clinical record for Resident #126, at 12:07 p.m., on 8/29/12 indicated the resident was admitted to the facility on 5/23/12, with diagnoses including, but not limited to, Alzheimer's dementia. A physician order, dated 8/10/12, indicated to add a diagnosis of dementia with behavioral disturbance. A physician order, dated 8/13/12, at 2:00 p.m., indicated to discontinue the Risperidone 0.5 milligrams and begin Risperidone 0.25 milligrams at bedtime. Another physician order, date 8/27/12, indicated Risperidone 0.25 milligrams one by mouth at bedtime, and discontinue Risperidone 0.5	F0282	F282 Services by Qualified Persons/Per Care Plan 1. Residents affected by the alleged deficient practice; ·One resident (#126) was found to have been affected by the alleged deficiency. Resident #126 is receiving medications as ordered. 2. All residents with physician orders are at risk to be affected by the alleged deficient practice; ·A 100% audit was completed on 8/30/12 & 8/31/12 of all physician orders with re-writes by the DNS, ADNS, and unit managers. ·When a physician order is written the licensed nurse assigned to the unit will ensure that the physician order is correctly transcribed to the medication administration record (MAR). Once transcribed to the MAR, the white copy of the physician order is placed in the nursing communication book, the yellow copy sent to pharmacy and the pink copy to be placed in the medical record chart. 3. Systems to ensure alleged deficient practice does not recur; ·Licensed nursing personnel will be in-serviced on the system for tracking and transcribing new	09/21/2012

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	milligrams. The Medication Administration Record (MAR) for August 2012, indicated the Risperidone 0.5 milligrams daily at bedtime was discontinued on 8/27/12 and Risperidone 0.25 milligrams at bedtime was started on 8/28/12. LPN #1 was interviewed at 12:50 p.m., on 8/29/12, and indicated the Nurse Practitioner had visited on 8/13/12, and wrote an order to decrease the Risperidone from 0.5 milligrams to 0.25 milligrams at bedtime. She indicated this was not caught by nursing, and the order was not transcribed to the MAR. The Director of Nursing Services provided an event report at 2:35 p.m. on 8/29/12, which was dated 8/27/12, at 1:00 p.m., regarding a medication error for the Risperidone. The medication/treatment error report indicated on 8/13/12, the Risperidone was decreased to 0.25 milligrams, but was not transferred to the MAR. LPN #1 provided a copy of the Nurse Practitioner's progress note, at 3:00 p.m. on 8/29/12, which was dated 8/13/12, and indicated an attempt would be made to decrease the		physician orders by the DNS or designee by 9/21/12.. ·Unit managers will educate newly hired licensed personnel during orientation on the system for tracking and transcribing new physician orders. ·Monday- Friday daily the unit manager will audit all new physician orders in the nursing communication book to ensure all orders are correctly transcribed to the MAR. ·A Medication Error Form will be completed with all orders that have not been transcribed. ·Nursing admin will monitor transcription audits and Medication Error Forms completed by unit manager daily Monday-Friday and conduct re-education and/or disciplinary action as needed. 4. Monitoring to ensure alleged deficient practice does not recur; ·DNS and/or designee will complete the Medication Errors CQI to ensure physician orders are correctly transcribed. CQI form will be completed weekly x 4, monthly x 3, and then quarterly thereafter to monitor. Findings will be brought to the CQI committee monthly then quarterly with tracking and trending discussed. If CQI reveals below the 90% threshold an action plan will be implemented. 5. Date of Completion: 09/21/12	

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	Risperidone. LPN #1 indicated LPN #2 was working on the memory care unit on 8/27/12, and discovered the Risperidone order from 8/13/12 had not been transcribed to the MAR, so informed the Nurse Practitioner, who then re-ordered the Risperidone to be decreased to 0.25 milligrams at bedtime. 3.1-35(g)(2)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to promptly notify the physician after an acute change in condition, failed to discontinue a continuous tube feeding after the resident had vomited, and failed to document an assessment and emergency medical treatment before being transported to the hospital, where the resident expired, for 1 of 1 resident reviewed for hospitalization (Resident #149). Findings include: The closed record for Resident #149 was reviewed on 8/28/12, at 3:27 p.m., and indicated the resident was admitted to the facility on 5/17/12 and discharged on 5/21/12. Diagnoses included respiratory insufficiency, dysphagia, diabetes mellitus type 2, obesity, hypertension, and PEG (Percutaneous Endoscopic Gastrostomy) tube placement. The resident status indicated the resident was a full code.	F0309	F309 **Provide Care/Service For Highest Well Being** ·Residents affected by the alleged deficient practice; ·One resident (#149) was found to have been affected by the alleged deficiency. This resident is deceased. 1.All residents with acute change in condition are at risk to be affected by the alleged deficient practice; ·The Physician will be notified with acute change of condition. If the physician does not return the call within a timely manner, the Medical Director will be called and the DNS will be notified. If the resident is experiencing a life threatening change, first aid measures are to be initiated as needed and 911 will be contacted immediately. The DNS will be notified as soon as the resident's needs are met. ·Licensed personnel are to take notes of any assessment information obtained, time the physician was notified, and any first aid measures initiated. Notes	09/21/2012

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	Further review of the closed record, at 11:09 a.m., on 8/29/12, indicated the resident was discharged to the hospital on 5/21/12 where respirations had ceased. Review of a History and Physical, dated 4/6/12, from the hospital, indicated the resident was admitted to the hospital on 4/6/12 due to Ventilator-dependent respiratory failure, status post tracheostomy, dysphagia, status post percutaneous endoscopic gastrostomy tube placement, ileus, and right upper extremity deep vein thrombosis. Review of the resident progress nursing notes indicated the following: 5/20/12 8:58 p.m. Resident was alert and oriented times 3 and cooperative, and able to follow simple tasks and answer questions appropriately. Gastrostomy tube (G-tube) dressing was dry and intact and no redness noted. Feeding through G-Tube was patent and less than 300 cubic centimeters (cc) of gastric content was noted. 5/21/12 at 12:41 a.m. The weekly nursing note indicated the resident usually slept throughout the night without difficulty, and awakened		are to be summarized and documented in the resident's medical record once the resident's needs are met. ·Resident's with acute change in condition will then be placed on Hot Charting and documented on every shift x 72 hours. 3. Systems to ensure alleged deficient practice does not recur; ·Licensed nursing personnel will be in-serviced on policy and procedure on Resident Change of Condition: Acute Medical Change and Life Threatening Change by the DNS and/or designee by 9/21/12. ·Staff Development Coordinator will educate newly hired licensed personnel during orientation on Resident Change of Condition: Acute Medical Change and Life Threatening Change. ·All acute medical changes and life threatening changes will be reviewed by the DNS or designee to assure appropriate interventions were initiated, the physician was notified and responded timely and documentation in the medical record is completed with re-education and/or disciplinary action as needed. 4. Monitoring to ensure alleged deficient practice does not recur; ·DNS and/or designee will complete the Change of Condition CQI to ensure assessment, notification and documentation of Resident Change of Condition. CQI form	

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	easily with verbal and tactile stimuli. The note indicated oxygen was given at 2 liters per minute via nasal cannula, respirations were even and unlabored, no distress or shortness of breath, abdomen was soft and nontender, and Glucerna was infusing through the G-tube. The nursing note further indicated the resident was complaining of stomach upset and nausea, and a medication was given through the G-tube for this. 5/21/12 at 2:15 a.m., indicated the resident was taking his oxygen tubing off numerous times during the shift, but no distress or shortness of breath was noted. 5/21/12 at 6:13 a.m., indicated the resident was noted to have 2 medium emesis of undigested tube feeding, no residual was noted, the abdomen was soft and nontender, bowel sounds present in all quadrants, and the resident stated he was coughing before the emesis. The resident also refused his breathing treatment saying it caused him to cough and get sick from the medication. The note indicated the physician was notified. 5/21/12 12:17 p.m., The resident did not complain of any nausea or vomiting this shift and the G-tube was patent and no residual noted when placement was checked. 5/21/12 12:20 p.m., The G-tube		will be completed weekly x 4, then monthly. Findings will be brought to the CQI committee monthly with tracking and trending discussed. If CQI reveals below the 90% threshold an action plan will be implemented. ·5. Date of Completion: 09/21/12	

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	dressing was changed and the area around the G-tube was red with a slight amount of brown drainage noted. Review of vital sign documentation, dated 5/21/12 at 1:03 a.m., indicated the resident's temperature was 97 degrees, pulse was 97 beats per minute, respirations were 18 per minute, blood pressure recorded at 110/78, and the oxygen saturation level was 92%. There were no further nursing progress notes documented until 8:05 p.m. on 5/21/12 when the note indicated the physician was called regarding the resident's condition; the resident was noted to be short of breath and tachycardiac and showed signs of cyanosis. Vital signs were taken and the pulse was 104, respirations 20, blood pressure 113/89, and oxygen saturation level between 45 and 85. The next entry indicated the physician was called again at 8:15 p.m. on 5/21/12, and a nursing note dated 5/21/12 at 8:25 p.m., indicated the physician called and left orders to send the resident to the hospital Emergency room. The note also indicated the resident's family was			

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	called. A nursing note, dated 5/21/12 at 8:57 p.m., indicated the physician was notified again and agreed for the EMS to transport the resident to the Emergency room. There was no further documentation in the medical record regarding this incident. QMA # 6 was interviewed at 1:47 p.m., on 8/29/12. She indicated she worked on East hall on the evening shift of 5/21/12, passing medications down both halls. She indicated Resident #149 had a G-tube so the nurse gave the resident his medications. She remembered the resident was transferred using a hoyer lift and remembered she had assisted him on the evening of 5/21/12 to use the urinal or bedpan. She indicated he was able to communicate his needs. She indicated the resident had an emesis and she reported this to the RN #5. She indicated at approximately 5:00 p.m., on 5/21/12, LPN #9 who was working on another hall had come over to help RN #5. She indicated she knew the resident was sick, and had reported the episode of emesis to RN#5. She indicated when she received report that day she was told			

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	to keep an eye on the resident because he was sick. QMA #6 indicated she went into the resident's room 2 or 3 times that evening because the resident had turned his call light on, one time for a bedpan and one time because of the emesis. LPN #8 was interviewed, at 2:06 p.m., on 8/29/12, and indicated on the morning of 5/21/12, during shift report, the previous shift reported the resident had vomited on the night shift. LPN #8 indicated she went in the resident's room and checked for residual from the feeding tube and there was none. She indicated the resident had a good day, was up in his chair, had visitors, went to therapy, had no vomiting. and did not complain of anything during her day shift. She indicated when she left the facility at 2:15 p.m., on 5/21/12, the resident was fine. RN #5 was interviewed, on the telephone, at 2:42 p.m., on 8/29/12. She indicated she had worked at the facility approximately one year. She indicated she worked the evening shift on 5/21/12 and was told in report the resident had vomited on third shift. She indicated that evening after the CNAs transferred the			

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	resident to bed from his chair, they called her and told her the resident was "turning blue." She indicated she did not remember what time this occurred, but she called the physician, who did not respond right away. She indicated she called him again and was told to send the resident to the hospital. She indicated she started working at 2:00 p.m., on 5/21/12, and the resident was fine at that time. She indicated he did refuse his breathing treatment, and indicated he was nauseous, and had an emesis in bed. She indicated she could not remember if she gave the resident anything through the feeding tube that night, but indicated she did not turn the feeding tube off that evening. She indicated the CNA called the nurse from the other hall and that nurse turned off the feeding. She indicated when the CNAs called her into the resident's room, he was cyanotic. She indicated at that time she told the CNAs to elevate his head because when she had gone into the room the resident was in bed and his head was "a little flat." She indicated she assessed the resident and took his vital signs, and then called the physician. She indicated the 2 CNAs were in the room when she left to call the physician. She indicated when the			

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	ambulance arrived, the resident was still breathing. CNA #7 was interviewed, on the telephone, at 4:28 p.m. on 8/29/12. She indicated she worked the East hall quite often and had taken care of the resident on 5/20/12 as well as 5/21/12. She indicated the resident was heavy set, was a 2 person assist, was younger, had a feeding tube and had to sit up and not lie down due to this. She indicated when she took care of him on 5/20/12, and the resident was fine. She indicated she and another CNA, who no longer worked at the facility, worked together on the East hall. She indicated at approximately 2:00 p.m., or so, she remembered seeing the resident, when she was checking rooms and indicated the resident didn't look like he was feeling well. She indicated he was sitting in the recliner, and looked "drained and tired." She indicated she and the other CNA did rounds, checking all the residents, toileting, and getting set up for dinner. She indicated Resident #149's call light went off around 6 p.m., and she asked the other CNA to go into the resident's room with her. She indicated the resident had vomited and was kind of "stooped over " in the chair. She indicated he seemed fairly			

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	alert, and told the CNAs he didn't feel good, and wanted to go to bed as he was afraid he would fall out of the chair. CNA #7 indicated they cleaned the resident up and put him to bed. She indicated he seemed a little better for 20 minutes or so, and they were in the room with him a large "chunk " of time that night. She indicated after 20 minutes, he vomited again. She indicated he was vomiting after that, sometimes a little bit, sometimes "quite a bit." She indicated around 7:30 -8 p.m., he "kind of went unresponsive." She indicated the first time the resident vomited she told RN #5. She indicated the nurse came in the room, and questioned the resident to see how he was doing. She indicated the resident was trying to tell them he was having trouble breathing. He would frequently take off his oxygen tubing, but indicated he had also done this prior to this night. CNA #7 indicated she didn't see any other nurses other then RN#5 in the resident's room that evening. She indicated RN#5 had hooked up a vital sign monitor in the room and his oxygen was "really low." She indicated she could see the resident's pulse and oxygen level on the monitor. She indicated the nurse had placed			

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	the vital sign monitor on him the first time he vomited. She indicated the resident had been unresponsive even before the ambulance arrived. She indicated the resident turned a "bluish purple" color before the ambulance arrived, and he was making a "coughing-gurgling" noise and it seemed he was "aspirating on his own vomit even though we had him sitting up." She indicated she and the other CNA were checking him often and called the nurse in quite a few times. She indicated the ambulance arrived around 9 p.m. and before this time the resident's oxygen level was running between 40 and 80, and most of the time bounced around the mid 50 to low 60's. She indicated the resident at first was trying to talk, but as time went on, was making hand gestures, moving his head around, and was not verbal. She indicated about 1/2 hour before the ambulance arrived, they could not get any response out of him, and he would just open his eyes. She indicated she noticed his skin started turning blue around 7:30 -8:00 p.m. The Director of Nursing Services (DNS) and LPN #1, the East hall Unit Manager were interviewed at 10:34 a.m., on 8/30/12. The DNS indicated she had only been employed at the			

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	facility since August, 2012 and was not employed at the time of the incident, however, LPN #1 was employed at that time. LPN #1 indicated she was not in the facility at the time of the incident, but received a phone call from RN #5 and RN #11, the evening shift supervisor. She indicated she was not available when they first called, but then called them back and was told about the resident's condition. She indicated by the time she returned their call, the resident had already been taken to the hospital. The DNS and LPN #1 were informed regarding the concerns about the documentation and assessment, and indicated they would investigate to see if they could find other documentation. The Director of Nursing Services (DNS) was interviewed, at 2:40 p.m., on 8/30/12, and indicated she could not find any further documentation in the clinical record. She indicated she spoke with LPN #9 who indicated she had helped RN#5 on 5/21/12, and had turned off the feeding tube herself. The DNS indicated the corporate nurse had reviewed the entire record on 8/29/12, and was not able to find any further documentation.			

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	155694	A. BUILDING 00 B. WING	08/31/2012

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	LPN #9 was interviewed, at 2:48 p.m., on 8/30/12, with the DNS present. She indicated she had worked on Central hall on the evening of 5/21/12, and the CNAs had come from East hall sometime on the evening of 5/21/12, and asked her to come to East Hall and check Resident #149. She indicated she thought they came to her because she had worked on East Hall for a long time and they knew her. She indicated when she went into the resident's room, he was in bed, and was not doing well. She indicated his color was very pale. She indicated his feeding tube was running and she turned it off as the CNAs had told her the resident had been vomiting. She indicated RN #5 was not in the resident's room when she went in, but after she left the room, she went and told RN #5 that she needed to call the physician and send the resident out to the hospital. She indicated she had never seen the resident before this, but his breathing was not good. She indicated she took his oxygen level and didn't remember what it was, but indicated it was not good. She indicated she did not observe cyanosis, but the resident was just "really pale." She indicated she didn't remember if he had his eyes			

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	opened, but he was not responsive. She indicated she listened to his chest and indicated, "I thought he had probably aspirated." The DNS was interviewed at 9:29 a.m., on 8/31/12, and indicated the only inservice completed related to the incident on Resident #149 was regarding calling 911 if the physician could not be reached. Review of the inservice, dated 5/24/12, and provided by the DNS, at this time, indicated, "send full code residents 911 for resp (respiratory) failure" and "get code status immediately upon admission to facility. " RN #11 was interviewed, with the DNS present, at 9:45 a.m., on 8/31/12. She indicated she had worked the evening of 5/21/12, and was the unit manager on Central hall. She indicated LPN #9 had told her that RN #5 was sending one of the residents to the hospital. RN #11 indicated she only went to the resident's room for approximately 5 minutes prior to the ambulance arriving, and did not assist with the resident, but only helped with the paper work. Review of an Emergency Medical			

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	Services (EMS) prehospital patient care report, dated 5/21/12, indicated they had responded to a 911 call regarding a resident with difficulty breathing. When they arrived at the resident's room, the resident was lying in a supine position in bed in a dark room. The resident had oxygen at 2 liters per minute via nasal cannula, and "has a feeding tube running. " The report indicated, "there was a lot of vomit in the patient's bed and all over the floor next to the bed and soiled hospital gown and linens on the chair next to the patient. Nursing staff reports that the patient had began to vomit at about 1800 this evening and that they believe that he had aspirated at that time. Nursing staff reports that at that point the (sic) moved the patient to the bed. Patients skin was purple and with respirations at 4 per minute. Patient still vomiting large amounts from nose and mouth." The resident was taken by cot and bagged using oxygen. The resident was suctioned "many times while in the ambulance" and when placed on the monitor showed asystole , no pulse, no respirations, and the pupils were dilated and non reactive. CPR was started without improvement or change.			

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	Review of the policy for change in condition, provided by the DNS, at 9:45 a.m., on 8/31/12, indicated the following: "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. " The Procedure for life threatening change indicated the licensed nurse would initiate appropriate first aid measures until emergency response personnel arrived on the scene, the licensed nurse would inform the attending physician, alternate physician, or Medical Director of resident status as soon as possible before, during, or after the change of condition occurred or when the resident crisis had been managed, and document the notification. Also, all nursing actions, physician contacts, and resident assessment information would be documented in the medical record, and the nursing supervisor would be notified immediately of life threatening changes of condition. The "Acute Medical Change" procedure indicated the following: Any sudden or serious change in a resident's condition manifested by a			

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	marked change in physical or mental behavior would be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical intervention. All nursing actions/interventions would be documented in the medical record as soon as possible after resident needs have been met. 3.1-37(a)			

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F0322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on record review and interview, the facility failed to ensure 1 resident in a sample of 2 with a feeding tube, Resident #149, received the proper treatment for his gastrostomy tube in order to prevent aspiration, resulting in the resident's deteriorating condition, transfer to hospital, and the resident expired. Findings include: The closed record for Resident #149 was reviewed on 8/28/12, at 3:27 p.m., and indicated the resident was admitted to the facility on 5/17/12 and discharged on 5/21/12. Diagnoses included respiratory insufficiency, dysphagia, diabetes mellitus type 2, obesity, hypertension, and PEG (Percutaneous Endoscopic Gastrostomy) tube placement. The resident status indicated the resident was a full code.	F0322	F322 NG Treatment/Services-Restore Eating Skills 1. Residents affected by the alleged deficient practice; ·One resident (#149) was found to have been affected by the alleged deficiency. 2 All residents with gastrostomy tubes are at risk to be affected by the alleged deficient practice; ·An audit of all resident's with gastrostomy tubes was conducted 9/17/12 to ensure all physician orders include gastric residual check frequency with intervention, and placement verification frequency. 3. Systems to ensure alleged deficient practice does not recur; ·Licensed nursing personnel will be in-serviced on policy and procedure for Enteral Therapy Resident Care and Enteral Therapy Physician Orders by the DNS and/or designee by 9/21/12. ·Staff Development Coordinator will educate newly hired licensed personnel during orientation on Enteral Therapy Resident Care	09/21/2012

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	Further review of the closed record, at 11:09 a.m., on 8/29/12, indicated the resident was discharged to the hospital on 5/21/12 where respirations had ceased. Review of a History and Physical, dated 4/6/12, from the hospital, indicated the resident was admitted to the hospital on 4/6/12 due to Ventilator-dependent respiratory failure, status post tracheostomy, dysphagia, status post percutaneous endoscopic gastrostomy tube placement, ileus, and right upper extremity deep vein thrombosis. Review of the resident progress nursing notes indicated the following: 5/20/12 8:58 p.m. Resident was alert and oriented times 3 and cooperative, and able to follow simple tasks and answer questions appropriately. Gastrostomy tube (G-tube) dressing was dry and intact and no redness noted. Feeding through G-Tube was patent and less than 300 cubic centimeters (cc) of gastric content was noted. 5/21/12 at 12:41 a.m. The weekly nursing note indicated the resident usually slept throughout the night without difficulty, and awakened easily with verbal and tactile stimuli.		and Enteral Therapy Physician Orders. ·Monday- Friday daily an audit of all residents with gastrostomy tubes will be completed to ensure gastric residual check frequency with intervention and placement verification frequency are completed and documented. DNS will review audits and provide further education and/or disciplinary action as needed. 4. Monitoring to ensure alleged deficient practice does not recur; ·DNS and/or designee will complete the Enteral Therapy CQI to physician orders include gastric residual check frequency with intervention, and placement verification frequency. CQI form will be completed weekly x 4, monthly x 3, and then quarterly thereafter to monitor. Findings will be brought to the CQI committee monthly then quarterly with tracking and trending discussed. If CQI reveals below the 90% threshold an action plan will be implemented. 5. Date of Completion: 09/21/12	

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	The note indicated oxygen was given at 2 liters per minute via nasal cannula, respirations were even and unlabored, no distress or shortness of breath, abdomen was soft and nontender, and Glucerna was infusing through the G-tube. The nursing note further indicated the resident was complaining of stomach upset and nausea, and a medication was given through the G-tube for this. 5/21/12 at 2:15 a.m., indicated the resident was taking his oxygen tubing off numerous times during the shift, but no distress or shortness of breath was noted. 5/21/12 at 6:13 a.m., indicated the resident was noted to have 2 medium emesis of undigested tube feeding, no residual was noted, the abdomen was soft and nontender, bowel sounds present in all quadrants, and the resident stated he was coughing before the emesis. The resident also refused his breathing treatment saying it caused him to cough and get sick from the medication. The note indicated the physician was notified. 5/21/12 12:17 p.m., The resident did not complain of any nausea or vomiting this shift and the G-tube was patent and no residual noted when placement was checked. 5/21/12 12:20 p.m., The G-tube dressing was changed and the area			

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	around the G-tube was red with a slight amount of brown drainage noted. Review of vital sign documentation, dated 5/21/12 at 1:03 a.m., indicated the resident's temperature was 97 degrees, pulse was 97 beats per minute, respirations were 18 per minute, blood pressure recorded at 110/78, and the oxygen saturation level was 92%. There were no further nursing progress notes documented until 8:05 p.m. on 5/21/12 when the note indicated the physician was called regarding the resident's condition; the resident was noted to be short of breath and tachycardiac and showed signs of cyanosis. Vital signs were taken and the pulse was 104, respirations 20, blood pressure 113/89, and oxygen saturation level between 45 and 85. The next entry indicated the physician was called again at 8:15 p.m. on 5/21/12, and a nursing note dated 5/21/12 at 8:25 p.m., indicated the physician called and left orders to send the resident to the hospital Emergency room. The note also indicated the resident's family was called.			

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	A nursing note, dated 5/21/12 at 8:57 p.m., indicated the physician was notified again and agreed for the EMS to transport the resident to the Emergency room. There was no further documentation in the medical record regarding this incident. QMA # 6 was interviewed at 1:47 p.m., on 8/29/12. She indicated she worked on East hall on the evening shift of 5/21/12, passing medications down both halls. She indicated Resident #149 had a G-tube so the nurse gave the resident his medications. She remembered the resident was transferred using a hoyer lift and remembered she had assisted him on the evening of 5/21/12 to use the urinal or bedpan. She indicated he was able to communicate his needs. She indicated the resident had an emesis and she reported this to the RN #5. She indicated at approximately 5:00 p.m., on 5/21/12, LPN #9 who was working on another hall had come over to help RN #5. She indicated she knew the resident was sick, and had reported the episode of emesis to RN#5. She indicated when she received report that day she was told to keep an eye on the resident			

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	because he was sick. QMA #6 indicated she went into the resident's room 2 or 3 times that evening because the resident had turned his call light on, one time for a bedpan and one time because of the emesis. LPN #8 was interviewed, at 2:06 p.m., on 8/29/12, and indicated on the morning of 5/21/12, during shift report, the previous shift reported the resident had vomited on the night shift. LPN #8 indicated she went in the resident's room and checked for residual from the feeding tube and there was none. She indicated the resident had a good day, was up in his chair, had visitors, went to therapy, had no vomiting. and did not complain of anything during her day shift. She indicated when she left the facility at 2:15 p.m., on 5/21/12, the resident was fine. RN #5 was interviewed, on the telephone, at 2:42 p.m., on 8/29/12. She indicated she had worked at the facility approximately one year. She indicated she worked the evening shift on 5/21/12 and was told in report the resident had vomited on third shift. She indicated that evening after the CNAs transferred the resident to bed from his chair, they			

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	called her and told her the resident was "turning blue." She indicated she did not remember what time this occurred, but she called the physician, who did not respond right away. She indicated she called him again and was told to send the resident to the hospital. She indicated she started working at 2:00 p.m., on 5/21/12, and the resident was fine at that time. She indicated he did refuse his breathing treatment, and indicated he was nauseous, and had an emesis in bed. She indicated she could not remember if she gave the resident anything through the feeding tube that night, but indicated she did not turn the feeding tube off that evening. She indicated the CNA called the nurse from the other hall and that nurse turned off the feeding. She indicated when the CNAs called her into the resident's room, he was cyanotic. She indicated at that time she told the CNAs to elevate his head because when she had gone into the room the resident was in bed and his head was "a little flat." She indicated she assessed the resident and took his vital signs, and then called the physician. She indicated the 2 CNAs were in the room when she left to call the physician. She indicated when the ambulance arrived, the resident was			

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	still breathing. CNA #7 was interviewed, on the telephone, at 4:28 p.m. on 8/29/12. She indicated she worked the East hall quite often and had taken care of the resident on 5/20/12 as well as 5/21/12. She indicated the resident was heavy set, was a 2 person assist, was younger, had a feeding tube and had to sit up and not lie down due to this. She indicated when she took care of him on 5/20/12, and the resident was fine. She indicated she and another CNA, who no longer worked at the facility, worked together on the East hall. She indicated at approximately 2:00 p.m., or so, she remembered seeing the resident, when she was checking rooms and indicated the resident didn't look like he was feeling well. She indicated he was sitting in the recliner, and looked "drained and tired." She indicated she and the other CNA did rounds, checking all the residents, toileting, and getting set up for dinner. She indicated Resident #149's call light went off around 6 p.m., and she asked the other CNA to go into the resident's room with her. She indicated the resident had vomited and was kind of "stooped over " in the chair. She indicated he seemed fairly alert, and told the CNAs he didn't feel			

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	good, and wanted to go to bed as he was afraid he would fall out of the chair. CNA #7 indicated they cleaned the resident up and put him to bed. She indicated he seemed a little better for 20 minutes or so, and they were in the room with him a large "chunk " of time that night. She indicated after 20 minutes, he vomited again. She indicated he was vomiting after that, sometimes a little bit, sometimes "quite a bit." She indicated around 7:30 -8 p.m., he "kind of went unresponsive." She indicated the first time the resident vomited she told RN #5. She indicated the nurse came in the room, and questioned the resident to see how he was doing. She indicated the resident was trying to tell them he was having trouble breathing. He would frequently take off his oxygen tubing, but indicated he had also done this prior to this night. CNA #7 indicated she didn't see any other nurses other then RN#5 in the resident's room that evening. She indicated RN#5 had hooked up a vital sign monitor in the room and his oxygen was "really low." She indicated she could see the resident's pulse and oxygen level on the monitor. She indicated the nurse had placed the vital sign monitor on him the first			

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	time he vomited. She indicated the resident had been unresponsive even before the ambulance arrived. She indicated the resident turned a "bluish purple" color before the ambulance arrived, and he was making a "coughing-gurgling" noise and it seemed he was "aspirating on his own vomit even though we had him sitting up." She indicated she and the other CNA were checking him often and called the nurse in quite a few times. She indicated the ambulance arrived around 9 p.m. and before this time the resident's oxygen level was running between 40 and 80, and most of the time bounced around the mid 50 to low 60's. She indicated the resident at first was trying to talk, but as time went on, was making hand gestures, moving his head around, and was not verbal. She indicated about 1/2 hour before the ambulance arrived, they could not get any response out of him, and he would just open his eyes. She indicated she noticed his skin started turning blue around 7:30 -8:00 p.m. The Director of Nursing Services (DNS) and LPN #1, the East hall Unit Manager were interviewed at 10:34 a.m., on 8/30/12. The DNS indicated she had only been employed at the facility since August, 2012 and was			

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	155694	A. BUILDING 00 B. WING	08/31/2012

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	not employed at the time of the incident, however, LPN #1 was employed at that time. LPN #1 indicated she was not in the facility at the time of the incident, but received a phone call from RN #5 and RN #11, the evening shift supervisor. She indicated she was not available when they first called, but then called them back and was told about the resident's condition. She indicated by the time she returned their call, the resident had already been taken to the hospital. The DNS and LPN #1 were informed regarding the concerns about the documentation and assessment, and indicated they would investigate to see if they could find other documentation. The Director of Nursing Services (DNS) was interviewed, at 2:40 p.m., on 8/30/12, and indicated she could not find any further documentation in the clinical record. She indicated she spoke with LPN #9 who indicated she had helped RN#5 on 5/21/12, and had turned off the feeding tube herself. The DNS indicated the corporate nurse had reviewed the entire record on 8/29/12, and was not able to find any further documentation.			

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	LPN #9 was interviewed, at 2:48 p.m., on 8/30/12, with the DNS present. She indicated she had worked on Central hall on the evening of 5/21/12, and the CNAs had come from East hall sometime on the evening of 5/21/12, and asked her to come to East Hall and check Resident #149. She indicated she thought they came to her because she had worked on East Hall for a long time and they knew her. She indicated when she went into the resident's room, he was in bed, and was not doing well. She indicated his color was very pale. She indicated his feeding tube was running and she turned it off as the CNAs had told her the resident had been vomiting. She indicated RN #5 was not in the resident's room when she went in, but after she left the room, she went and told RN #5 that she needed to call the physician and send the resident out to the hospital. She indicated she had never seen the resident before this, but his breathing was not good. She indicated she took his oxygen level and didn't remember what it was, but indicated it was not good. She indicated she did not observe cyanosis, but the resident was just "really pale." She indicated she didn't remember if he had his eyes opened, but he was not responsive.			

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	She indicated she listened to his chest and indicated, "I thought he had probably aspirated." The DNS was interviewed at 9:29 a.m., on 8/31/12, and indicated the only inservice completed related to the incident on Resident #149 was regarding calling 911 if the physician could not be reached. Review of the inservice, dated 5/24/12, and provided by the DNS, at this time, indicated, "send full code residents 911 for resp (respiratory) failure" and "get code status immediately upon admission to facility. " RN #11 was interviewed, with the DNS present, at 9:45 a.m., on 8/31/12. She indicated she had worked the evening of 5/21/12, and was the unit manager on Central hall. She indicated LPN #9 had told her that RN #5 was sending one of the residents to the hospital. RN #11 indicated she only went to the resident's room for approximately 5 minutes prior to the ambulance arriving, and did not assist with the resident, but only helped with the paper work. Review of an Emergency Medical Services (EMS) prehospital patient			

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	care report, dated 5/21/12, indicated they had responded to a 911 call regarding a resident with difficulty breathing. When they arrived at the resident's room, the resident was lying in a supine position in bed in a dark room. The resident had oxygen at 2 liters per minute via nasal cannula, and "has a feeding tube running. " The report indicated, "there was a lot of vomit in the patient's bed and all over the floor next to the bed and soiled hospital gown and linens on the chair next to the patient. Nursing staff reports that the patient had began to vomit at about 1800 this evening and that they believe that he had aspirated at that time. Nursing staff reports that at that point the (sic) moved the patient to the bed. Patients skin was purple and with respirations at 4 per minute. Patient still vomiting large amounts from nose and mouth." The resident was taken by cot and bagged using oxygen. The resident was suctioned "many times while in the ambulance" and when placed on the monitor showed asystole , no pulse, no respirations, and the pupils were dilated and non reactive. CPR was started without improvement or change.			

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	Review of the policy for change in condition, provided by the DNS, at 9:45 a.m., on 8/31/12, indicated the following: "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. " The Procedure for life threatening change indicated the licensed nurse would initiate appropriate first aid measures until emergency response personnel arrived on the scene, the licensed nurse would inform the attending physician, alternate physician, or Medical Director of resident status as soon as possible before, during, or after the change of condition occurred or when the resident crisis had been managed, and document the notification. Also, all nursing actions, physician contacts, and resident assessment information would be documented in the medical record, and the nursing supervisor would be notified immediately of life threatening changes of condition. The "Acute Medical Change" procedure indicated the following: Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental			

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	behavior would be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical intervention. All nursing actions/interventions would be documented in the medical record as soon as possible after resident needs have been met. Review of the facility policy for Enteral Therapy, provided by the DNS, at 11:50 a.m., on 8/31/12, indicated It was the policy of the facility to ensure the physician's plan of care was specific and that licensed nurses implement the physician's plan of care in a consistant manner. The policy indicated a licensed nurse will take, note, and implement physician orders for enteral therapy, and orders should be obtained as follows: Gastric residual check frequency with intervention, and placement verification frequency. 3.1-44(a)(2)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure 13 of 25 ambulatory residents residing in the memory care unit were kept safe while housekeeping staff mopped the floors in the dining room. Finding includes: On 8/28/12 at 9:30 a.m. observation of the "Memory Care" dining room indicated the floor was being mopped and was wet. The housekeeping staff, who was mopping the floor, stated "be careful the floor is wet." During observation of the room at 9:31 a.m., there were 5 residents seated at tables in the room. Three residents were ambulatory and 2 were in wheelchairs. Housekeeping staff left the area and there was no other facility staff in the room. One resident was observed to go in and out of the room with her walker and knock down the wet floor signs which were at the two entrances to the dining room.	F0323	F323 Free of Accident Hazards/Supervision/Devices1. Residents affected by the alleged deficient practice; ·Thirteen of 25 ambulatory residents were found to have been affected by the alleged deficiency. Residents are being monitored to prevent entering wet floor area. 2 All residents residing on the cottage are at risk to be affected by the alleged deficient practice; ·A waist high "guideline" safety strap that attaches to each side of the dining room entrances will be utilized with a wet floor sign when floors are wet to prevent residents from entering the wet floor area. The design of th strap has a spring mechanism on one end to alleviate fall risk. It was assessed for safety by DNS. Nursing/Housekeeping/Administrative Staff will also be responsible to monitor residents when floor is wet and "guideline" is engaged to assure they do not enter the wet floor area. 3. Systems to ensure alleged deficient practice does not recur; ·Nursing personnel and housekeeping staff will be in-serviced on ensuring that the	09/21/2012

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	On 8/29/12 at 9:30 a.m. housekeeping staff came to the "Memory Care" dining room and proceeded to mop the floor. During observation, one resident walked into the dining room and the housekeeping staff walked her to a table, sat her down and then continued to mop. At 9:42 a.m. another resident walked into the dining room and sat down at a table., At 9:43 a.m. another resident walked into the room, across the wet floor and sat down at a table. The housekeeping staff did not place wet floor signs at the entrance to the dining room. Interview with the housekeeping supervisor on 8/30/12 at 1:45 p.m. indicated staff mop the memory care dining room after each meal. She indicated it is hard to keep residents from wandering into the room, and indicated they are often sitting at the table. 3.1-45(a)(1)		"guideline" strap and the wet floor sign are in place when floors are wet and preventing residents from walking on the wet floor by the DNS and/or designee by 9/21/12. ·Staff Development Coordinator will educate newly hired licensed personnel and housekeeping personnel during orientation on ensuring that the "guideline" strap and the wet floor sign are in place when floors are wet and preventing residents from walking on the wet floor. ·A daily audit will be conducted on one meal service per day rotating meals to assure the "guideline" strap and the wet floor sign are in place when floors are wet and Nursing/Housekeeping/Administrative Staff will monitor that residents are not entering the wet floor area. 4. Monitoring to ensure alleged deficient practice does not recur; ·DNS and/or designee will complete the Environmental Safety/Nursing CQI to ensure resident safety when floors are wet. CQI form will be completed weekly x 4, monthly x 3, and then quarterly thereafter to monitor. Findings will be brought to the CQI committee monthly then quarterly with tracking and trending discussed. If CQI reveals below the 90% threshold an action plan will be implemented. 5. Date of Completion: 09/21/12	

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based observation, record review, and interview, the facility failed to	F0441	F441 Infection Control, Prevent Spread, Linens1. Residents	09/21/2012

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	ensure nursing staff washed hands during 1 of 3 medication passes, which affected 3 of 15 residents observed (#147, #10, and #112). Findings include: On 8/29/12 from 3:30 P.M. until 4:20 P.M., Nurse #12 was continuously observed while administering medications to residents on the 500 Hall on the Central Unit. At 3:30 P.M., Nurse #12 was observed to prepare oral medications at the medication cart for Resident #50 The nurse was observed to use a gel based hand sanitizer to clean her hands. The nurse was observed to take the medications into the resident's room, administer the medications, and return to the medication cart. The nurse was not observed to use hand sanitizer or to wash her hands after administering the medications. The nurse was then observed to prepare eye drop medications for Resident #147. The nurse was observed to enter the resident's room and put on exam gloves. The nurse was not observed to wash her hands prior to putting on the gloves. The nurse was observed to administer the eye drops to the resident and then remove the gloves		affected by the alleged deficient practice; ·Three residents (#147, #10, and #112) were found to have been affected by the alleged deficiency. Staff are using appropriate infection control measures when passing medications to these residents. 2 All residents receiving medications and eye drops are at risk to be affected by the alleged deficient practice; ·Residents will be assessed as needed for any s/s of possible infection and the physician notified as needed. ·Licensed personnel will assure hand hygiene is completed between residents, when hands become contaminated and prior to donning and removing gloves. 3. Systems to ensure alleged deficient practice does not recur; ·Licensed nursing personnel will be in-serviced that hand hygiene is completed between residents, when hands become contaminated and prior to donning and removing gloves by the DNS and/or designee by 9/21/12. ·Staff Development Coordinator will educate newly hired licensed personnel during orientation that hand hygiene being completed between residents, when hands become contaminated and prior to donning and removing gloves. ·Three times weekly an audit of licensed nursing personnel will be completed to ensure hand	

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	and return to the medication cart in the hallway. The nurse was not observed to wash her hands or to use hand sanitizer after removing the gloves. The nurse was then observed to prepare oral medications for Resident #10. The nurse was observed to enter the resident's room, obtain his blood pressure, and then administer the medications to the resident. The nurse was not observed to wash her hands or to use hand sanitizer prior to administering the medications. The nurse was then observed to return to the medication cart to prepare oral medications for another resident. Prior to preparing the medications, the nurse was observed to use a gel based hand sanitizer. The nurse was observed to enter the resident's room and administer the medication. The nurse was not observed to use hand sanitizer or to wash her hands after administering the medications. The nurse then returned to the medication cart and prepared oral medications for Resident #112. The nurse was observed to enter the resident's room and administer the medications. The nurse was not observed to wash her hands or to use hand sanitizer prior to administering the medications. After administering the medications, the nurse was observed to wash her		hygiene is being completed between residents, when hands become contaminated and prior to donning and removing gloves. Audit will encompass different nurses on all three shifts. 4. Monitoring to ensure alleged deficient practice does not recur; ·DNS and/or designee will complete the Infection Control CQI to ensure appropriate hand hygiene. CQI form will be completed weekly x 4, monthly x 3, and then quarterly thereafter to monitor. Findings will be brought to the CQI committee monthly then quarterly with tracking and trending discussed. If CQI reveals below the 90% threshold an action plan will be implemented. 5. Date of Completion: 09/21/12	

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	hands with soap and water. The facility's Director of Nursing Services Specialist (DNSS) was interviewed on 8/31/2012 at 8:50 A.M. During the interview, the DNSS indicated nursing staff was to use hand sanitizer before and after administering medication to each resident. The DNSS indicated nursing staff was to wash hands with soap and water after every third resident or if hands become soiled or contaminated. The DNSS further indicated nursing staff was to wash hands with soap and water before and after using exam gloves. A nursing skills validation checksheet, entitled "Medication Pass Procedure", dated 7/2011, was provided by the DNSS on 8/31/2012 at 9:50 A.M. The DNSS indicated the checksheet also served as the facility's hand washing policy. The checksheet indicated "Hand hygiene MUST be performed between residents." 3.1-18(l)			